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Open regulation and practice in assisted dying : How Switzerland compares with the Netherlands and Oregon

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Abstract: The Netherlands, Oregon and Switzerland are the only areas in the world where assistance in dying has legally been practised in recent years. This article provides a detailed comparison of the history of the origins, legislation, monitoring systems and the extent of assistance in dying in these three places. It shows that the actual practice in Switzerland which, unlike Oregon, also allows assistance in suicide by means of infusions or gastric tubes, can today be technically quite similar to the permitted practice of active euthanasia on request in the Netherlands. Considering the preconditions restricting these practices, Swiss regulations are the most open, in that the law requires neither a medical second opinion (as in both the Netherlands and Oregon) nor the existence of a terminal illness (as in Oregon) as prerequisite to assistance in dying. In 2001, the proportion of assisted deaths (as reported to the authorities) in all deaths was almost ten times higher in the Netherlands (1.5% of all deaths) then in Oregon (<0.1% of all deaths) or Switzerland (0.2% of all deaths). The analysis of the different normative concepts underlying legislation reveals that in the Netherlands the basis for non-prosecution lies in the conflict of the physician's duties to respect life versus relief of suffering, while in the USA and in Switzerland the right-to-die concept plays a major role. These two concepts allow appreciation of distinctions between the roles of the physician in end-of-life practices and between assisted suicide and voluntary active euthanasia.

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Peer reviewed article

Open regulation and practice in assisted dying

How Switzerland compares with the Netherlands and Oregon

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Summary

The Netherlands, Oregon and Switzerland are the only areas in the world where assistance in dying has legally been practised in recent years. This article provides a detailed comparison of the history of the origins, legislation, monitoring systems and the extent of assistance in dying in these three places. It shows that the actual practice in Switzerland which, unlike Oregon, also allows assistance in suicide by means of infusions or gastric tubes, can today be technically quite similar to the permitted practice of active euthanasia on request in the Netherlands. Considering the preconditions restricting these practices, Swiss regulations are the most open, in that the law requires neither a medical second opinion (as in both the Netherlands and Oregon) nor the existence of a terminal illness (as in Oregon) as prerequisite to assistance in dying. In 2001, the proportion of assisted deaths (as reported to the authorities) in all deaths was almost ten times higher in the Netherlands (1.5% of all deaths) then in Oregon (<0.1% of all deaths) or Switzerland (0.2% of all deaths).

The analysis of the different normative concepts underlying legislation reveals that in the Netherlands the basis for non-prosecution lies in the conflict of the physician's duties to respect life versus relief of suffering, while in the USA and in Switzerland the right-to-die concept plays a major role. These two concepts allow appreciation of distinctions between the roles of the physician in end-of-life practices and between assisted suicide and voluntary active euthanasia.

Key words: assisted suicide; euthanasia; end-of-life; right-to-die; Netherlands; Oregon; Switzerland

Introduction

Moral and legal aspects of medical decisions intentionally shortening the life of patients suffering from an incurable or terminal disease have been intensively discussed for some years in many modern industrialised nations. Passive euthanasia is widespread today: although frequently not regulated explicitly by law, it is not considered to be illegal in most western countries. In contrast, active euthanasia is punishable by law almost everywhere, as is physician-assisted suicide. Of the few countries where doctors may use drugs in lethal doses for seriously ill patients who wish to die, the Netherlands in particular have attained great significance in global terms. Likewise, in the USA, non-penalisation of assisted suicide for the terminally ill, as has been practised in Oregon for some years, is widely discussed.

It is less well-known that for many years similar practices have been widespread in Switzerland, against a background of almost one hundred years' of non-penalisation of suicide assistance without self-interest. This article describes the existing Swiss regulations and practice in comparison with the situation in the Netherlands and the State of Oregon, USA. In Oregon and Switzerland, physicians are allowed to prescribe or supply a drug in lethal dose (physician-assisted suicide), while in the Netherlands they are even permitted to administer it to their patients (active voluntary euthanasia). The term "assistance in dying" will be used to encompass both these types of actions: table 1. However, it should be kept in mind that passive and indirect forms of end-of-life practices are of more importance in everyday medical practice than assisted dying.

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Table 1
Terms and definitions as used in this paper.

End-of-life decisions / practices (= decisions / practices shortening life)[1]: The intentional decision / act to bring about the death of someone suffering from an incurable or terminal disease (on request or for mercy reasons). Includes direct and indirect actions as well as omissions (non-treatment decisions).
Assisted suicide (= assistance in suicide): The prescription or supplying of drugs with the explicit intention of enabling someone to end his or her life. In cases where the drugs are prescribed/supplied by a physician: physician-assisted suicide.
Voluntary active euthanasia: The administration of drugs (predominantly performed by a physician) with the explicit intention of ending someone's life at his or her explicit request.
Assisted dying (= assistance in dying): The overall concept for assisted suicide and voluntary active euthanasia.

[1] the common term euthanasia is in a state of flux since it is increasingly used in a narrow sense as voluntary active euthanasia

Origins of open assistance in dying

In 1973, in the Netherlands, a regional court had to decide on a case in which a physician had administered a lethal dose of morphine to her terminally ill mother, in response to her serious and persistent request. The court determined that a physician is allowed to prevent severe and irreversible suffering, even if this shortens the patient's life [1]. In this, and subsequent judgements, ie, in the context of case law, criteria were formulated that had to be fulfilled before a physician could raise a defence to a charge of euthanasia. If these criteria were met, the physician could invoke a defence of necessity, based on a conflict of duties (to save life vs to relieve suffering). In 1984, the Royal Dutch Medical Association joined in the discussion, attempting to clarify the criteria accepted within the medical profession [1]. These developments took place against a background where not only termination of life on request but also assistance in suicide were punishable under the Dutch Penal Code. From the very beginning of the debate, however, these two forms of assisted dying were considered together and the responsibility of the person assisting in either of these practices was judged to be equivalent [2]. In addition, at the end of the 1980s, a general consensus was reached in the Netherlands that "euthanasia" would be understood exclusively as "intentionally taking the life of another person upon his or her request". Hence, "euthanasia" within this narrow definition does not include passive or indirect forms of medical decisions shortening life nor non-voluntary forms of active euthanasia. The latter actions were designated as LAWER ("life terminating acts without explicit request of the patient") [3]. In the nineties, assisted dying remained illegal but was tolerated. From 1990–1991 and 1995–1996, two research projects studied the incidence of euthanasia and other medical end-of-life decisions [2, 3]. The results of these investigations attracted a great deal of both national and international attention. It was the first time that a complete overview was obtained of the extent and nature of medical end-of-life decisions in any country. Partly due to the initiation of the first study, the Minister of Justice and the Royal Dutch Medical Association agreed upon a notification procedure with the intention of creating a mechanism for public control [4]. Finally, in April 2001, the non-penalisation of a doctor who fulfilled the "criteria of due care" in assisted suicide or active euthanasia on request was adopted in the Dutch Penal Code [5].

Developments of assisted dying in Oregon have to be viewed in the light of the activities of non-medical right-to-die organisations such as the Denver-based Hemlock Society or the Seattle-based Compassion in Dying [6]. In 1991, the founder of the Hemlock society, Derek Humphrey, wrote a book giving detailed instructions on how to kill oneself. In 1993–1994, Compassion in Dying acted in an uncertain legal environment when assisting in the suicides of 46 terminally-ill patients in the State of Washington [7]. While the attempts to legalise physician-assisted suicide failed in several other American States, voters in Oregon approved the Death with Dignity Act by 51% to 49% in November 1994 [8]. This act legalised assistance in dying by a physician by the prescription of drugs. The day after the Act was passed, a local judge permanently enjoined its implementation, concluding that it violated the US Constitution [6]. However, in June 1997, the US Supreme Court unanimously ruled that there is neither a constitutional right nor a constitutional prohibition of assisted suicide or active euthanasia [9]. In the meantime, resistance to the act had increased. The Oregon Medical Association opposed legalisation, although a survey showed that 60% of Oregon physicians thought physician-assisted suicide should be legal in some cases, and 46% might be willing to prescribe a lethal drug if it were legal to do so [10]. In October 1997, the Oregonians approved the measure by 60% to 40%. On November 6th, 2001, US Attorney General John Ashcroft ruled that the Oregon law legalising physician-assisted suicide violated the federal Controlled Substances Act, a 1970 law designed to prevent drug abuse and illegal drug trafficking [11]. This attempt to neutralise the Death with Dignity Act was rejected in April 2002 by a federal judge who ruled that the Justice Department did not have the authority to overturn the statute [12].

In Switzerland, the development of assisted dying has been based on two specific prerequisites. The first is the non-penalisation of assisted suicide under Article 115 of the Swiss Penal Code, as long

as it is performed without motives of self-interest [13]. The second is the decision of the right-to-die organisation Exit Deutsche Schweiz, founded in Zurich in 1982, not to strive primarily for greater liberalisation of active euthanasia in Switzerland, but rather to use the liberal legislation concerning assisted suicide to offer such assistance on request to severely ill people wishing to die [14]. Conversely, the priority of the Swiss French Association Exit ADMD ("Association pour le droit de mourir dans la dignité") was to legalise a certain type of living will in case the medical condition of the member is considered incurable or hopeless [15]. During the first years, "Exit Deutsche Schweiz" sent a "suicide manual" to all persons over the age of 18 years who had been a member of the organisation for at least three months. This manual contained precise instructions for committing suicide by placing a plastic bag over the head and/or by taking a cocktail of drugs [16]. This cocktail consisted of a considerable number of hypnotics, which the person wanting to die had to get from different physicians, for instance by pretending to suffer from sleeplessness. Some members of Exit did not find these instructions to be sufficiently practicable. Therefore, since 1990, Exit has offered members suffering from a disease with "poor prognosis, unbearable suffering or unreasonable disability" who wish to die, personal guidance through suicide [17]. This is carried out by the ingestion of a lethal dose (10–15 g) of barbiturates prescribed by a physician with the explicit intention of enabling the patient to end his or her life [15]. This development only became possible once the initial conflict between Exit and the medical profession which characterised the early years [14] had markedly declined.

On the political level, a working group set up by the Swiss Federal Council in 1996 presented a report in which the majority of the group pleaded for non-penalisation of voluntary active euthanasia, with certain restrictions [18]. In December 2001, the Swiss Parliament rejected the Cavalli Initiative requesting that the proposals of the majority of the working group be put into practice [19]. In the same session, however, the Parliament also rejected the Vallender Initiative, which intended to restrict assistance in suicide performed by right-to-die organisations and to prohibit it completely for physicians. However, it was hardly challenged in Parliament that there is a basic need for a precise formulation of legislation which has been implemented since the first half of the last century (Article 115 of the Penal Code) but was never intended for the organised assistance in dying for the severely ill.

Conclusions: The development in the Netherlands is characterised by the close normative association of assisted suicide and active euthanasia (understood as active euthanasia on request) as well as the early integration of the medical profession in drawing up criteria under which these practices should be ethically and legally tolerated. In the USA and in Switzerland, the activities of the right-to-die organisations, often opposed by the official stand of the medical profession, played an important role. To date, Oregon remains the only state in the USA which has explicitly legalised an open practice of assisted suicide, although with extensive restrictions. In Switzerland, where assisted suicide without any self-interest has not been illegal for almost a hundred years, assistance in suicide practised by right-to-die organisations is tolerated by the investigating authorities.

Legislation

In the Netherlands, assisting in suicide as well as killing on request is a criminal offence even today. However, the Dutch "Euthanasia law" passed in April 2001 determines that this offence shall not be punishable if committed by a physician who has met the requirements of due care and has informed the municipal coroner. The requirements of due care comprise that the physician must

- be convinced that the patient's request was voluntary and carefully considered
- be convinced that the patient was facing unremitting and unbearable suffering
- have advised the patient concerning his/her situation and prospects
- have reached the conclusion together with the patient that there was no reasonable alternative to the patient's situation
- have consulted at least one other independent physician, who examined the patient and gave a written opinion on the requirements of due care
- have terminated life or assisted in the suicide in a medically appropriate manner [5].

The Oregon Death with Dignity Act allows adult Oregon residents to obtain a prescription of a lethal medication for self-administration from his/her physician, if the following conditions are met. The patient must

- be capable (able to make and communicate decisions about his/her health care)
- have a terminal disease (incurable and irreversible disease that is expected to lead to death within six months).
- have made one written and two oral requests to die to his/her primary physician.

The primary physician is required

- to confirm the above conditions together with a consultant, and to refer the patient for counselling, if either believes that the patient's judgement is impaired by depression or some other psychiatric or psychological disorder
- to inform the patient of all feasible alternatives, such as comfort care, hospice care, and pain-control options [8].

Furthermore the law states that "nothing shall be construed to authorise a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia". It is worth noting that, to date, this section of the law has apparently been understood to mean the self-administration of lethal drugs using exclusively the oral route of administration.

In Switzerland, Art. 115 of the Penal Code states:

– Whosoever incites another person to commit suicide or helps him or her to do so from motives of self-interest, will be liable to a maximum of 5 years imprisonment if the suicide is carried out or attempted [13].

This means that, under Swiss law, if there is no self-interest on the part of the assistant, then there is no penalty for assisted suicide. This holds for all cases in which a person of age wishing to die is competent. Medical conditions to restrict assistance in suicide are not given by the Swiss Penal Code. However, the Zurich Administrative Court formulated more limiting conditions for participating physicians [20]. In addition to the mental competence of the person wishing to die, the court stipulated "a medical indication in the sense of a terminal illness with an inevitable progression to death" as a minimal requirement for physician-assisted suicide. A central issue of the interpretation of Article 115 concerns the question whether assisted suicide means by definition the oral route of administration. At first widely unnoticed by the general public, Exit began in 1997 to help people who wished to die but had difficulties in swallowing, to prepare lethal infusions or even to help with the introduction of such substances into gastric tubes [21]. These cases have been classed – and thus tolerated – by the investigating authorities as assisted suicide, since the final step causing death was actually carried out by the person wanting to die [22].

Conclusions: Considering actual practice, the Dutch law is more open than that in Oregon or Switzerland, in that it allows not only assisted suicide but also active euthanasia on request. However, in Switzerland the term assisted suicide is interpreted far more extensively than in Oregon by tolerating techniques (eg, intravenous self-administration) that come very close to what is designated "euthanasia" in the Netherlands (see table 2). On the other hand, considering the prerequisites imposed, Swiss regulation is the most open since the law lays down the fewest restrictive preconditions. Corresponding restrictions in Oregon are clearly tighter than those in the Netherlands, in particular the limitation to terminally ill patients (table 2). Further basic differences concern the role of the physician. In the Netherlands, non-penalisation applies to both assisted suicide and termination of life on request, but exclusively for physicians. The Oregon Death with Dignity Act is also related to physicians, although the presence of a physician at the suicide is not required. In contrast, in Switzerland, Article 115 of the Penal Code applies equally to everyone. The role of the physician in assisted suicide as carried out by right-to-die organisations is, at present, almost solely related to the prescription of the barbiturates (table 2).

Table 2

Overview of the legislation governing assisted dying in The Netherlands, Oregon and Switzerland (obl. = obligatory, opt. = optional)

Legal regulation		Netherlands	Oregon	Switzerland
Admissible actions: Drugs in lethal doses prescribed by the physician …	… self-administered orally by the patient	yes	yes	yes
	… self-administered (last step) by the patient using intravenous infusion or gastric tube	yes	no	yes
	… administered by physician	yes	no	no
Restricting preconditions	Explicit request and decision-making capacity	yes	yes	yes
	Terminal illness	no	yes	no[1]
	Assistance restricted to physicians	yes	(yes)[2]	no[3]
	Medical second opinion	yes	yes	no
	Period of persistence	(yes)[4]	yes	no
Reporting system	Coroner	obl.	no	obl.
	Police / Prosecutor	opt.	no	obl.
	Review committee	obl.	no	no
	Health division	no	obl.	no

[1] According to a Zurich Administrative Court decision, however, the minimum prerequisite for physician-assisted suicide is a terminally ill patient. Exit's own criteria are "poor prognosis, unbearable suffering or unreasonable disability"

[2] Presence of the physician at the suicide not required

[3] Role of the physician in practice actually given by the prescription-only status of the barbiturates used

[4] Legally given by the condition "carefully considered request" and in practice by a system in which the patient is closely attached to his/her family doctor

Monitoring system

In the Netherlands, physicians who have assisted a patient in dying must inform the municipal coroner of the death due to unnatural manner and submit a report. The coroner will notify one of the five regional review committees for termination of life on request, whose task it is to review the case. These committees include a physician and an expert in the field of ethics, with a lawyer in the chair. If the committee decides that the doctor has fulfilled all the requirements of due care, the case is closed. If, however, the committee is in any doubt, it will send a report to the Public Prosecutor who may decide to prosecute. The committees issue a joint annual report to the ministry of justice [5].

In Oregon, physicians must report all prescriptions for lethal medications that they write to the Oregon Health Division [23]. The latter is required by the Act to develop a reporting system for monitoring and collecting information on physician-assisted suicide [8]. To fulfil this mandate, the Health Division uses a system involving physician prescription reports and death certificate reviews [23]. In the case of missing or discrepant data, physicians are contacted by the Division. Apparently it would be within the responsibility of the Health Division to inform the Public Prosecutor in case of harsh abuse. The Health Division has to write an annual statistical report on the information collected and make it available to the public.

In Switzerland, the cantonal health regulations require healthcare workers to notify the police without delay of all unnatural deaths, which include suicide (and also assisted suicide). These deaths are then examined by the investigative authorities together with a medical officer. There is no central registration body to which district investigative authorities are obliged to report cases of assisted suicide. Nor has the Federal Statistics Office any such data. In the case of suicide, the mortality statistics are based on the method employed and the cause of death but do not differentiate between "ordinary" and assisted suicide [24].

Conclusions: In The Netherlands, there is an elaborate control system involving a special review committee. In Oregon the decision to notify a case that has violated the legal conditions seems to lie principally with the Oregon Health Division. In Switzerland, assisted suicide is examined by the investigative authorities as death from unnatural cause, in the same way as an "ordinary" suicide (table 2).

Extent of assisted dying – notification rate

As explained in the previous section, in both the Netherlands and Oregon there are central case registers and periodic reviews of assisted dying. In the year 2001, 2054 cases of assisted dying were officially notified in the Netherlands. In 1819 of these cases the aid given was classed as euthanasia, in 191 cases as physician-assisted suicide and in 44 cases there was a combination of physician-assisted suicide and euthanasia [25]. This corresponds to 1.5% of the approximately 140,000 annual deaths in this country.

In 2001, 33 physicians in Oregon wrote 44 prescriptions for lethal doses of medication. Of these 44 patients, 19 died after ingesting the medication, 14 died from their underlying disease, and 11 were still alive on December 31st, 2001. Additionally, two patients who received prescriptions during 2000 died in 2001 after ingesting their medication [26]. Hence, 21 people died in 2001 under the Death with Dignity Act. This is less then 0.1% of the total 30,000 deaths occurring in Oregon every year.

Since Switzerland has no centralised notification system for assisted suicide, there is strong reliance on figures from the right-to-die organisations themselves. From its own records, Exit Deutsche Schweiz provided companionship in 124 cases of suicide among Swiss residents in 2001 [27]. This represents 0.2% of the 63,000 deaths occurring in Switzerland every year. The situation is further complicated by the fact that right-to-die societies other than Exit Deutsche Schweiz have been offering assistance in suicide, as well as an increase of "suicide tourism" to Switzerland [28–31]. Corresponding figures from other right-to-die organisations are only partly known, but should be considerably lower then those from Exit Deutsche Schweiz.

It may be assumed that, as everywhere else, in addition to the cases notified there will be a certain number of unreported cases carried out outside the law, whether as assisted suicide, voluntary or non-voluntary euthanasia [2, 3, 9, 32–34]. The number of effective but actually illegal cases can be estimated by studies which assure doctors of strict anonymity. The most reliable information in this respect may be obtained from death certificate studies, first carried out in 1990 by van der Maas and co-workers in the Netherlands [3] (see above). The most recent study from the Netherlands [2] reported a figure for 1995 of 3,600 cases of assisted dying (of which more than 90% were voluntary active euthanasia), corresponding to 2.7% of all deaths. In that year 1466 of these 3600 cases of assisted death were officially reported. This gives a notification rate of 41% [35]. The death certificate study of 1995 also showed that in the Netherlands almost 1000 deaths (0.7% of all deaths) were due

to active euthanasia without the explicit request of the patient (LAWER). In contrast, the proportion of unreported cases is not known in Oregon and Switzerland. In the near future, however, such figures should be available for Switzerland through participation in a joint project death certificate study [36–38].

Conclusions: It is obligatory to notify cases of assisted dying in the Netherlands as well as in both Oregon and Switzerland, although Switzerland lacks a central register. A death certificate study which investigates the incidence of un-notified cases of assisted dying is being carried out at present, for the third time in the Netherlands and for the first time in Switzerland.

Discussion

Assisted dying: hastening death or right to die?

Two types of justification for assistance in dying can be differentiated: the "hastening-death" concept has its origins in the medical experience that an active and intentional medical act to shorten life seems justified as a last medical resort when facing cruel processes of dying [39]. The main prerequisite of such a rationale is the existence of a terminal condition which has led to physical suffering that can no longer be controlled by medical means. In contrast, the "right-to-die" concept has its origins in the philosophical conviction that every person must have the freedom to decide on the time and manner of his/her own death, and that this liberty must also be ensured for those with a severe incurable illness. Assisted dying viewed from this perspective is a form of suicide, which is neither a morally doubtful nor a pathological decision but rather one that is free and rational: "Freitod" – a term which has no analogue in any other language [40]. In general proponents of right-to-die come from a non-medical background, and not uncommonly from philosophical or legal circles. In contrast, physicians seem to support (if at all) hastening death as justification for assisted dying. However, many of them may be of the opinion that such medical actions should not be determined by law but should remain within the private sphere of the physician-patient relationship.

Even if these two concepts are intermingled in the everyday reality of social and political discourse on end-of-life practices, it becomes obvious that the developments in the Netherlands have emerged from the hastening-death concept, while those in the USA and Switzerland have followed the right-to-die concept.

In the Netherlands, physician-assisted dying became tolerated on the recognition of a physician's conflict of duty between sustaining life and relieving suffering of dying patients. In contrast, developments in the north-west of the USA and in Switzerland have mainly been determined by the activities of non-medical right-to-die organisations which strive against the official stand of the medical profession. However, "Exit Deutsche Schweiz" has been able to convert its ideals into political reality to a greater extent than is the case anywhere in the USA.

Assisted dying: a medical task?

The logic of liberalising assisted dying as hastening death was its medicalisation, as happened in the Netherlands. In complete contrast to the Dutch, the Swiss regulations on assisted suicide do not even mention the role of the physician, and Exit Deutsche Schweiz was originally clearly opposed to any medical participation.

However, a Dutch medical ethicist reported recently on a "shift to autonomy" in his country, ie, that euthanasia is seen more and more as a patient's choice instead of as a last medical resort [39]. And in an interview following the passing of the euthanasia law, the Dutch Minister of Health stated that she could also envisage forms of assisted dying which "have nothing to do with euthanasia law, with medicine or doctors" [41].

On the other hand in Switzerland, the former opposition of Exit Deutsche Schweiz to the medical profession has waned considerably. Today, a few physicians have even expressed a possible relief of their moral burden by collaborating with right-to-die societies, in a field that extends beyond medicine. In a journal for primary care workers, a family doctor recently reported on his collaboration with a right-to-die organisation in the case of the suicide of a severely ill patient [42] and concluded: "to respect the freedom of the patient, to help him over obstacles, to guide him through the twilight and confront death with him; this is all part of my work as a doctor. But these tasks (respecting another person's freedom, giving someone support, confronting death) are by no means specific medical tasks but much rather general humanitarian requirements. Therefore, why not suggest to others – people from the church, lawyers, and everyone who feels motivated – that they assist those close to them in committing suicide?" And in autumn 2001, the Swiss Academy of Medical Sciences stated in a press release that, in contrast to their earlier position, they can today conceive that "in certain situations, assistance in suicide may also be a medical responsibility" [43]. It seems, therefore, that in Switzerland the way is basically open for regulation of the role of the physician and of medical preconditions in assisted suicide [44]. However, decided opposition against any psychiatric gatekeeper role for assisted suicide has been expressed recently [45].

Assisted suicide or voluntary active euthanasia?

If, as is the case in the Netherlands, assisted suicide and voluntary active euthanasia are viewed as very closely related and if assisted dying is seen almost exclusively as a medical task of hastening death, then it is logical to include both assisted suicide and voluntary active euthanasia in an open regulation of medical end-of-life practices.

The situation can be viewed differently in places where, by legal tradition and moral discourse, suicide and assisted suicide, but not killing on request are interpreted as freedom of the individual, as is the case in Switzerland [43] and in some states in the USA [40]. It is then logically coherent to restrict assistance in dying to assisted suicide. Accordingly, the role and responsibility of the doctor can be defined in a more differentiated manner than in voluntary active euthanasia, which involves a direct medical action on the patient to end his or her life [46]. In assisted suicide the final act is always carried out by the person wanting to die. This personal act banishes also the fear of opening the floodgates to the same extent as for active euthanasia [47]. Whoever argues for flexible boundaries between assisted suicide and voluntary active euthanasia, should consider that this would also apply to at least the same extent to the boundary between voluntary and non-voluntary active euthanasia. For example, whether active euthanasia should still be designated as voluntary on the basis of a corresponding request in a living will is just one of the questions which arise. However, with regulations covering solely assisted suicide, warnings on a purely practical level should not be ignored. A Dutch study found an increased complication rate for oral assisted suicide in comparison with active euthanasia, in particular with respect to vomiting and time elapsing between ingestion and death [48]. In contrast to this, reports from Washington and Oregon [7, 23, 49–51] have found no serious problems with assisted suicide using oral barbiturates. A debate on this question in the New England Journal of Medicine [52, 53] concludes that oral assisted suicide with barbiturates is generally quite certain if careful antiemesis is given. It must be accepted that death may sometimes be delayed for hours and in extreme cases for more than a day. With purely oral administration, as practised in Oregon, terminally ill people who wish to die but who have difficulties in swallowing are excluded. The more recent Swiss practice of assisted suicide by the parenteral or intragastric route allows assistance in dying in these cases. However, the medical nature of these procedures raises more then ever the question of the role of the physician.

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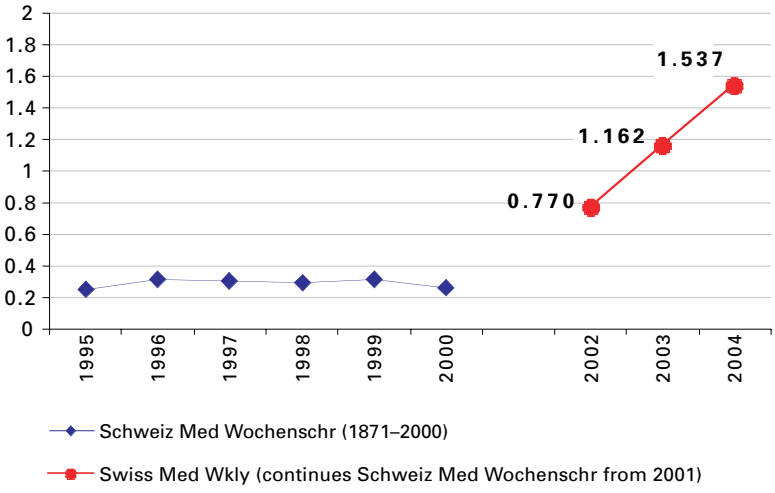

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